



REFERRAL FORM

Date: _____

SUNRISE SUPPORT

Student's Name: _____ Birthdate: _____

School: _____ Grade: _____

Name/position of person making referral: _____

Parent/Guardian: _____

Contact Information:

Address: _____

Phone Numbers: _____

Reason for referral: (Please add supporting documentation if appropriate)

Services previously/currently being accessed:

- | | |
|--|--|
| <input type="checkbox"/> Child & Youth Services | <input type="checkbox"/> Probation |
| <input type="checkbox"/> Alberta Health Services: Addictions | <input type="checkbox"/> Roots & Wings |
| <input type="checkbox"/> Family Support For Children With Disabilities | <input type="checkbox"/> Alberta Health Services: Children's Mental Health |
| <input type="checkbox"/> Attendance Board/Youth Justice Committee | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Counselling | |

Emotional/Behavioral Assessment Completed

☐ Yes

☐ No

Have parents been contacted regarding this referral?

☐ Yes

☐ No

Consent Form has been signed by the parent and student

☐ Yes

☐ No

November 22, 2011